HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1740

REIMBURSEMENT OF FEDERALLY QUALIFIED HEALTH CENTERS

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Historical Note: This chapter is based substantially upon Title 17, chapter 1323 of the Hawaii Administrative Rules. [Eff 9/3/92; R 08/01/94]

§17-1740-1 Purpose and general principles. (a) The primary goal of this chapter is to define the procedures that will be used to comply with the requirement of 42 U.S.C. §1396a(a)(13)(E). That legislation is significant because it recognizes a new type of health care provider, the federally qualified health center (FQHC), and requires that FQHCs be paid one hundred per cent of the reasonable costs of delivering certain health care items and services to medicaid-eligible recipients.

(b) The provision of this chapter pertain only to the fee-for-service medical assistance program. These provisions do not apply to Hawaii Health QUEST.

(c) As elaborated in this chapter, each FQHC shall be reimbursed according to the following general principles:

(1) Each FQHC shall be reimbursed for one hundred per cent of the reasonable costs incurred in providing covered items and services to eligible recipients. What constitutes reasonable costs and the amount of total medicaid reimbursable costs shall be determined in accordance with medicare principles of reimbursement;

(2) The department shall pay each FQHC interim rates for covered items and services provided to eligible recipients;

(3) If the department determines that the total interim payments to a particular FQHC fall significantly short of its expected total medicaid reimbursable costs, then the department may make a lump-sum interim payment to that FQHC;

(4) Each FQHC shall complete and submit a cost report to the department. In addition, the FQHC shall maintain and make available to the department all records that are necessary or appropriate to document both the scope of its operations and business costs;

(5) A final settlement comparing all interim payments received by a FQHC from the department to its total medicaid reimbursable costs shall be conducted. The total medicaid reimbursable costs shall be determined from the FQHC's finalized cost report;

(6) If a FQHC disagrees with the final settlement of its cost report, the entity may appeal

pursuant to the procedures defined in chapter 17-1736;

(7) Any departures from medicare principles of reimbursement that the department applies in determining either reasonable costs or total medicaid reimbursable costs shall be identified in these regulations; and

(8) A FQHC shall be paid solely on a cost reimbursement basis for all covered items and services that it delivers to eligible recipients. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-2 Definitions. As used in this chapter:

"Annual reports" means a yearly written submission from a FQHC to the department of the following:

(1) A cost report in a form prepared or previously approved by the department;

(2) A working trial balance;

(3) A provider cost report questionnaire;

(4) An audited financial statement;

(5) A written disclosure of any appeal items included in the cost report; and

(6) Such other accounting, financial, and statistical information that the department requests.

"Claims-based interim payment" means a periodic reimbursement to a FQHC by the department for the provision of services allowed under the state medicaid program. Payments are issued in response to clean claims submitted by the entity for reimbursement of covered items and services.

"Clean Claim" means a claim which does not require any additional information from the provider of the services or from a third party, is not under review for medical necessity, and is not under investigation for fraud or abuse.

"Covered items and services" means health care services or items which are:

(1) Within the legal authority of a FQHC to deliver;

(2) Actually provided by the FQHC, either directly or under arrangements;

(3) Covered benefits under the medicaid program;

(4) Provided to an eligible recipient;

(5) Additional requirements imposed generally on

payment for benefits under the medicaid program;

(6) Delivered exclusively by health care professionals and other persons acting within the lawful scope of their authority to provide services; and

(7) Additional requirements included in the FQHCs provider agreement.

"Eligible recipient" means a person that is eligible for benefits under the medicaid program.

"Final settlement" or "finalized" means that a comparison has been made between the aggregate of interim payments a FQHC has received from the department for a defined cost reporting period and the total medicaid reimbursable costs claimed for the same period and the findings issued in an original or revised notice of program reimbursement. Final settlements may be reactivated at the department's discretion.

"FQHC" means an entity that, based upon the recommendation of the Health Resources and Services Administration within the Public Health Service, has been determined by the Secretary of U. S. Department of Health and Human Services to meet the qualifications for a federally qualified health center, as defined in 42 U.S.C. §1396d(l).

"Health care professional" means one of the following persons:

(1) A physician;

(2) A physician's assistant;

(3) A nurse practitioner;

(4) A nurse midwife;

(5) A clinical social worker; or

(6) A clinical psychologist.

"Incident to" means items or services which are:

(1) Provided to an eligible recipient;

(2) Provided incident to the professional practice of a health care professional;

(3) Of a type commonly delivered in a FQHC;

(4) Of a type commonly rendered without charge or included in the FQHC's bill;

(5) Furnished as an incidental, although integral, part of the health care professional's services; and

(6) Furnished under the direct, personal supervision of the health care professional.

"Interim rate" means a reimbursement fee established by the department to pay a FQHC for covered

items and services prior to final settlement.

"Lump-sum interim payment" means any payment made by the department to a FQHC for covered items and services to eligible recipients other than a claims-based interim payment.

"Medicare principles of reimbursement" means that body of accounting, cost finding, cost allocation, and cost limit principles that has developed over time in the administration of the medicare program under Title XVIII of the Social Security Act. It includes, without limitation, the principles identified in the following authorities:

(1) The Social Security Act, 42 U.S.C. §§1395 et seq.;

(2) The regulations promulgated pursuant to that Act, including 42 C.F.R. Part 413;

(3) Manuals published by the Health Care Financing Administration, including HCFA Pub. No. 15; and

(4) Intermediary letters and bulletins disseminated by the Health Care Financing Administration.

"Notice of program reimbursement (NPR)" means a written decision of the department concerning the final amount owing to or from a FQHC for a particular cost reporting period. Issuance of a NPR often coincides with the finalized cost report.

"Provider agreement" means the contract between the department and the FQHC for the delivery of covered items and services to eligible recipients.

"Reasonable costs" means the amount of reasonable and allowable costs that a FQHC incurs in delivering health care services, as determined under medicare principles of reimbursement.

"Total interim payments" means the total amount of lump-sum interim payments and claims-based interim payments received by a FQHC for a particular cost reporting period.

"Total medicaid reimbursable costs" means that portion of reasonable costs that are properly allocated to the medicaid program under medicare principles of reimbursement. Those costs shall be identified on the FQHC's finalized cost report.

"Visit" means a face-to-face encounter between an eligible recipient who is a patient of the FQHC and either:

(1) A health care professional; or

(2) Another person who delivers health care services incident to the health care professional's practice; and
(3) The visit results in the eligible recipient receiving a covered item or service.

Encounters with more than one health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-3 Responsibility to document costs. (a) It is the FQHC's responsibility to document to the department's satisfaction all the information and statistics necessary to calculate the FQHC's total medicaid reimbursable costs.

(b) A FQHC shall not be reimbursed for costs incurred that are inadequately documented and improperly allocated to the medicaid program or both.

(c) All subcontracts that a FQHC enters shall be in writing and comply with the requirements of §1861(v)(1)(I) of the Social Security Act, 42 U.S.C. §1395x(v)(1)(I). That statute requires subcontractors who exceed a defined work threshold to maintain records and make their books and records available to the Secretary of the Department of Health and Human Services and the Comptroller General of the United States. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-4 Categories of claims-based interim rates. Because the costs of providing covered items and services vary significantly based upon the type of item or service, the department has created the following four categories of claims-based interim rates:

(1) The facility-specific medical service interim rate;
(2) The dental procedure interim rate;
(3) The vision service interim rate; and
(4) The home health agency interim rate.

Other than these four categories, the department shall

not make claims-based interim payments to a FQHC. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-5 The medical service interim rate. The department shall pay the FQHC a facility-specific medical service interim rate for each visit if the facility submits a clean claim for one of the following:

(1) A covered item or service on form 1500; or

(2) Early and periodic screening, diagnostic and treatment (EPSDT) services on form 209. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-6 Medical service interim rate determination. In either setting initially or adjusting the medical service interim rate, the department shall:

(1) Utilize the best available data concerning the costs that the department expects the FQHC to incur; and

(2) Consider:

(A) Shortfalls or overpayments in other categories of interim rates; and

(B) The costs of covered items or services that the FQHC delivers but receives no interim payment, such as covered items or services billed on form 204 (Prescription Drugs) or form 208 (Medical Transportation). [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-7 The dental procedure interim rate. Submission of a clean claim for a covered item or service on form 151 shall result in payment of the interim dental procedure rate for the particular covered item or service provided. The interim rate is set according to the existing charge screens and payment levels that the department applies to all

dental procedures covered under the medicaid program. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-8 The vision service interim rate. Submission of a clean claim for a covered item or service on form 205A shall result in payment of the interim vision service rate for the particular item or service provided. The interim rate for each item or service is set according to the same charge screens and payment levels the department applies to all vision services covered under the medicaid program. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-9 The home health agency interim rate. Submission of a clean claim for a covered item or service on form UB-82 shall result in payment of the interim home health agency interim rate for the particular covered item or service. The interim rate for each type of service is set according to the same charge screens and payment levels the department applies to all home health agency services covered under the medicaid program. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-10 Written notice of medical service interim rate. The department shall notify each FQHC in writing of its initial medical service interim rate and all subsequent revisions to that rate. Upon written request, the department shall provide information on the current dental procedures, vision services, and home health agency interim rates. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-11 Billing. (a) Each FQHC shall complete and submit to the department's fiscal agent the appropriate claim form for any covered item or service, regardless of whether a claims-based interim payment will result.

(b) The claims shall either be on forms provided by the department or in a format that the department has indicated in advance is acceptable. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-12 Departure from medicare cost principles. (a) The department shall not apply the lower of cost or charge principle in determining the reimbursement of FQHCs.

(b) If a FQHC fails to submit a claim form for a covered item or service, then the cost of delivering that item or service is not an allowable cost. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-13 Interim payment shortfall. If a FQHC experiences a significant shortfall between its total medicaid reimbursable costs and its total interim payments, the FQHC may request, in writing, an adjustment of its medical service interim rate, a lump-sum interim payment or both. The FQHC shall be responsible to document to the reasonable satisfaction of the department that an adjustment is warranted. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-14 Accounting systems. Each FQHC shall adopt and maintain an accounting system that identifies costs and accumulates statistics (e.g., patient visits) in a manner that conforms to medicare principles of reimbursement. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-15 Annual reporting requirements. Each FQHC shall deliver its annual reports to the department no later than three months after the close of the FQHC's fiscal year. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-16 Delinquent annual reports. (a) If acceptable and complete annual reports are not received

within three months after the close of the FQHC's fiscal year, then the department shall send a written notice to the FQHC that all classes of its interim payments will be reduced by at least twenty per cent if the missing sections of the annual reports are not received within thirty days of the written notice.

(b) If the FQHC does not supply acceptable and complete annual reports within the time required by the department's written notice, then the department shall begin withholding at least twenty per cent of all classes of the FQHC's interim payments and send a second written notice to the FQHC indicating as follows:

(1) That all classes of its interim payments shall be suspended entirely if acceptable and complete annual reports are not received within thirty days of the second written notice; and

(2) That if the FQHC does not supply acceptable and complete annual reports within the time required by the department's second written notice, then the following amounts will be considered overpayments:

(A) All classes of interim payments made during the accounting period for which the annual reports have not been filed;

(B) All classes of interim payments made subsequent to the accounting period to which the annual reports relate; and

(C) Any lump-sum interim payments, current financing payments, accelerated payments on account, and overpayments from prior periods.

(c) If the FQHC does not supply acceptable and complete annual reports within the time required by the department's second written notice, then the department shall suspend entirely all classes of interim payments to the FQHC and begin procedures to collect the overpayments, including interest. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-17 Extension of time to file cost report. Granting a time extension to a FQHC to file annual reports shall be at the department's discretion.

A FQHC request for a filing extension shall be in writing and must demonstrate good cause as defined in HCFA Pub. No. 13-2. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-18 Maintaining records. Each FQHC shall keep accounting, financial, and statistical records for each cost reporting year for at least three years after the cost report for that fiscal year is finalized. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-19 Desk review. The department shall analyze all cost reports after receipt to verify that each FQHC has complied with medicaid cost reporting requirements. The analysis may include a sample review of financial and statistical records of participating FQHCs. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-20 Field audits. The department or its fiscal agent may conduct an on-site audit of any or all cost reports filed by FQHCs. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-21 Notice of program reimbursement. Upon conclusion of each desk review or on-site audit, the department shall calculate a final payment that is due to or from each FQHC. The amount shall be calculated by comparing the aggregate interim payments with the amount of total medicaid reimbursable costs as indicated on the finalized cost report. The department shall include the calculation in a NPR issued to the FQHC. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-22 Appeal of audit findings. Notwithstanding any provision or requirement to the contrary, a FQHC shall be considered a provider for the purpose of pursuing an appeal under chapter 17-1736. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-23 Repayment plan. The department may develop a repayment plan with an overpaid FQHC. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)

§17-1740-24 Provider agreement. Each FQHC shall execute a provider agreement with the department. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §6404)